

**STATE OF MICHIGAN**  
**DEPARTMENT OF CONSUMER & INDUSTRY SERVICES**  
**OFFICE OF FINANCIAL AND INSURANCE SERVICES**  
**Before the Commissioner of Financial and Insurance Services**

In the matter of

XXXXXXXXXXXXXXXXXXXXXXX

Petitioner,

File No. 49479-001

v

Blue Cross Blue Shield of Michigan

Respondent.

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Issued and entered  
this 22nd day of May 2003  
by Linda A. Watters  
Commissioner

**ORDER**

**I**  
**PROCEDURAL BACKGROUND**

On August 23, 2002, XXXXXXXXXXXX. on behalf of XXXXXXXXXXXX (Petitioner), filed a request for external review with the Commissioner of the Office of Financial and Insurance Services, under the Patient's Right to Independent Review Act (PRIRA), MCL 550.1901 *et seq.* After a review of the submitted material, the Commissioner accepted the request.

A determination on medical issues was required. The Commissioner assigned the case to National Medical Reviews (NMR), an independent review organization (IRO). The Commissioner directed NMR to provide the opinion and recommendation of a medical expert. On October 3, 2002, the IRO completed its review and sent it to the Office of Financial and Insurance Services (OFIS).

## **II FACTUAL BACKGROUND**

The Petitioner's health care coverage is through BCBSM's Super Care 1 Group Health Benefit Certificate (Super Care 1). Petitioner has a history of systemic disorders that caused external root resorption of teeth numbers 24 and 25. As a result, these teeth had to be extracted. The extractions left a defect in the left alveolar ridge. This defect required repair.

Petitioner's dentist requested pre-authorization for:

- Repair of the alveolar ridge defect with an onlay graft
- IV sedation
- The placement of implants to provide the stimulation needed to maintain bone and correct the edentulism.

The total cost for the requested services was \$6102.00.

On XXXXXXXXXXXX, BCBSM allowed coverage for the onlay graft and IV sedation at the cost of \$2700.00, but denied authorization for the implants at the cost of \$3402.00. Petitioner's dentist states the implants are required to maintain the bone grown with the graft or the graft will atrophy.

BCBSM denied authorization for the implants. According to BCBSM, implants are specifically excluded under the Petitioner's Certificate of Coverage. Petitioner exhausted the internal grievance process and received BCBSM's final determination in this matter.

## **III ISSUE**

Did BCBSM properly deny coverage for implants according to Petitioner's Certificate of Coverage?

## IV ANALYSIS

### Petitioner's Argument

Petitioner's dentist states that the implants are required to provide the stimulation needed to maintain bone and correct the edentulous area. If the implants are not placed the graft will atrophy.

### BCBSM's Argument

BCBSM's Certificate of Coverage states in pertinent part:

#### **Section 19.7 Dental Services**

Dental treatment by a licensed dentist or dental surgeon required because of an accidental injury to sound, natural teeth sustained while covered by this plan and only if coverage has been continuous since the date of the accidental injury. Charges by a dental surgeon for the removal of cysts and tumors of the mouth and jaw, and the extraction of impacted teeth are covered.

An initial mandibular orthopedic repositioning appliance is covered at 90% of the approved amount, up to the maximum of \$450. Benefits include molding, fitting of, and office visits for adjustments to the appliance. Repair or replacement of appliance is not covered.

#### **Section 21 Exclusions and Limitations**

The following exclusions and limitations apply to the Super Care 1 plan. These are in addition to limitations appearing elsewhere in this Certificate:

\* \* \*

- Dental care (except as previously specified) including repairs of supporting structures for partial or complete dentures, dental implants, extractions, extraction repairs, bite splints, braces and appliances, and other dental work or treatment;

The proposed dental services were not caused by an accidental injury. In addition, implants are specifically excluded under the Super Care 1 Certificate. BCBSM argues the

authorization of \$2,700.00 complies with Petitioner's Certificate requirements and it believes it was appropriate and correct to deny coverage for the dental implants.

#### IRO Recommendation

A dentist (who is also a board-certified physician in maxillofacial surgery) reviewed this case. Based on the Petitioner's Certificate of Coverage, the IRO determined BCBSM's decision regarding the dental/medical nature of the requested services was appropriate.

#### Commissioner's Review

The Certificate of Coverage controls the analysis in this matter. The focus of this analysis is whether BCBSM properly denied Petitioner's request for implants. The Certificate, as quoted above in BCBSM's argument (*Sections 19.7 and 21*), excludes:

- Coverage for implants
- Dental services, except for:
  1. Accidental injury,
  2. Removal of cyst or tumor of the mouth and jaw,
  3. Extraction of an impacted tooth.

Petitioner's dentist argues the implants are needed:

- To stimulate the bone,
- maintain the graft and prevent atrophy, and
- to correct the edentulism.

BCBSM argues:

- there was no accidental injury, no removal of cyst or tumor of the mouth and jaw and no extraction of an impacted tooth,
- implants are not covered, and
- their denial of the dental services was appropriate and correct under the terms of Petitioner's Certificate of Coverage.

The IRO determined, based on Petitioner's Certificate of Coverage, BCBSM's denial of authorization for implants was appropriate.

BCBSM authorized payment for the onlay graft and IV sedation, but denied authorization for the implants. The Commissioner agrees with this conclusion. The Certificate specifically

excludes implants. Therefore, the \$2700.00 BCBSM authorized is correct and is the limit of its liability in this matter. The Commissioner finds that BCBSM properly applied its maximum payment level to the charges for Petitioner's surgery.

**V  
ORDER**

The Commissioner upholds BCBSM's final adverse determination in this matter. This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this order may seek judicial review no later than sixty days from the date of this order in the circuit court for the county where the covered person resides or in the Circuit Court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Services, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

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Linda A. Watters  
Commissioner